CALIFORNIA HIV/AIDS POLICY RESEARCH CENTERS

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Making the Case for Conditional Cash Transfers: The Incentives & Prevention Study (TIPS)

BACKGROUND

In 2023, 39,182 people were newly diagnosed with HIV in the U.S., and Black and Latinx individuals accounted for 72% of new diagnoses despite making up only about 33% of the populations. Black individuals were diagnosed at 8.4 times the rate of White individuals; Latinx individuals at 5.2 times the rate. This burden is not matched by PrEP access based on the PrEP-to-Need Ratio (a measure of how many people are using PrEP relative to new diagnoses). White individuals had roughly 42 PrEP users for every new diagnosis, compared to just 8 for Latinx individuals and 6 for Black individuals. In other words, White individuals use PrEP at roughly seven times the rate of their racial and ethnic counterparts, relative to need. Structural racism is increasingly recognized as a fundamental cause of these disparities, shaping access to prevention tools like PrEP.

TIPS is the first study to explore the acceptability and design preferences of a CCT aimed at improving PrEP uptake & HIV testing among Black and Latino cisgender men who have sex with men (MSM) in the U.S.

Black and Latino MSM represent a disproportionate rate of new HIV diagnoses nationally and locally, and PrEP access alone has not closed that gap. TIPS combined qualitative in-depth interviews on intervention acceptability, assessed using the Theoretical Framework of Acceptability, with a structured survey utilizing discrete choice experiments (DCEs) to test which specific intervention attributes participants preferred. Intervention attributes included the following:

- Payment Amount: $300/year; $600/year; $1,200/year for participation
- Payment Frequency: monthly; quarterly (every 3 months); and annually (lump sum)
- Payment Type: cash payment; gift card payment
- PrEP Type: oral daily PrEP; injectable PrEP (every 2 months)

METHODS

Twenty (n=20) Black and Latino cisgender MSM completed qualitative interviews; 133 completed the structured survey including the DCE. The study sample included a diversity of race, ethnicity,

age, education status, housing status, and PrEP experience (i.e., current users, past users, and never users), capturing perspectives across various lived experiences.

RESULTS

Participants responded positively overall and described several concerns that tell us what a CCT program for HIV prevention ought to look like.

Attitudes about PrEP CCTs: Participants described incentives for taking PrEP as meaningful financial relief, easing everyday economic pressures.

This motivation was especially strong among participants who had never used PrEP or had used it in the past, and participants broadly felt like their own communities would accept CCTs for PrEP use.

Concerns about PrEP CCTs: Beyond programming logistics like transportation and clinic hours, stigma emerged as a consistent barrier to participating in CCTs. Participating visibly in a program that promoted PrEP carried real costs for people already managing stigma or identity-based discrimination.

> "Just because of how expensive life is getting right now, I wouldn't mind getting paid for not only staying protected against HIV and be on top of my sexual health, but also that benefit could just really help out with just some expensive costs that are coming with inflation."
>
> **- Latino, 27, bachelor's degree, stably housed, current PrEP user**

> "…[T]here's a lot of stigma behind taking PrEP. So some people don't really want others to know that they're on PrEP, so just maintaining confidentiality is important."
>
> **- Latino, 21, high school graduate, unpaid housing arrangements, current PrEP user**

Perceived effectiveness of PrEP CCTs: Participants largely believed a CCT would work, particularly for getting people started on PrEP, though these attitudes differed by group. Current PrEP users described the incentive as reinforcing a habit they already maintained and had experience with, while non-users and previous users described it as the external push needed to move from intention to action.

This suggests that CCTs may be perceived as generally effective for PrEP initiation and sustainment, but whether it translates into sustained behavior change, something the literature points out as well, may depend on program design and individual context.

Participants consistently preferred higher payments, frequent payouts, and cash. Participants did not have a strong preference for specific PrEP type (oral vs. injectable).

In a peer-reviewed analysis of the same 133 participants, choosing a $1,200 payment over $300 increased the likelihood of selecting a PrEP-based CCT by 35.2 percentage points. Participants also preferred cash over gift cards by a meaningful margin: 9.4 percentage points for the PrEP CCT and 11 percentage points for the HIV testing CCT. These preferences held consistently regardless of their PrEP status or housing status, though housing stability comparison involved a small subgroup of the sample (24 of 133 participants). Nonetheless, there were no differences detected in this subgroup. One interesting finding is that participants currently on PrEP placed somewhat greater value on higher payments compared to non-users.

> **"…[M]aybe individuals who are maybe struggling financially and a cash transfer or something of fifty to a hundred dollars per month could help them out tremendously…"**
>
> **- Black, 40, graduate student, stably housed, current PrEP user**

RECOMMENDATIONS

TIPS provides a starting point for a CCT design to improve PrEP maintenance and HIV testing, but real implementation questions still need to be answered.

Design CCTs around what participants ask for. The evidence points to a universal design of a CCT for HIV prevention which is $1,200 per year, cash, and monthly or quarterly disbursements. Though this conclusion rests on small sample size, it should be revisited as funded pilots could help generate more insightful and nuanced data. It should be noted that research with people with HIV shows they are more often concerned that research incentives are too low rather than they are coercively high - a useful, population-specific counterpoint to assuming payment itself is the primary ethical risk.

Deliver CCTs through trusted partners, and address payment mechanics honestly. Participants named stigma, medical mistrust, and confidentiality as preconditions for engaging in such programs at all. Separately, cash payments can interact negatively with existing public benefits for some participants (e.g., general assistance/relief, SSI), a concern raised directly in the qualitative interviews. Program design should address this before implementation, not after.